

# **PBS Insurance Underwriting Corp.**

## **Application Checklist**

With the fully completed, signed and dated application, you **must** submit the following information:

1. Copy of Curriculum Vitae ( Resume ).
2. Current Business Letterhead.
3. Copy of all Licenses and Board Certifications.
4. Currently valued loss runs from all prior Insurance Companies ( 10 yrs. )
5. Copy of current Insurance Declarations page.
6. Articles of Incorporation. ( if applicable )

**Note: Submission of completed application confers no obligation upon the company, broker, agent and / or any associate to bind coverage.**

### **Note:**

This is an application for Insurance, not an Insurance Binder. The application is subject to underwriting review and approval by the company. The effective date, prior acts date ( **aka:** retroactive date or nose coverage ) and additional classification and / or rating aspects of this application are also subject to approval by the company. In no event can the requested coverage effective date be prior to the date of this application is received by us, No offer of coverage exists unless and until this application is accepted / approved by the company and you have received written notification of said acceptance.

### **Instructions:**

1. Answer all questions; if a question is not applicable, state **“NOT APPLICABLE”**
2. If Space is insufficient to answer any question fully, attach a separate sheet.
3. The Application must be signed and dated by the applicant.
4. If the answer to any question is none, state **“NONE”**
5. Please do not complete the application earlier than **60 days** before proposed effective.

Preparers Signature: \_\_\_\_\_ Date \_\_\_\_\_



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WARNING - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

PHYSICIAN'S PROFESSIONAL LIABILITY POLICY NEW BUSINESS APPLICATION

Instructions: All questions must be answered. Please type or print clearly. No coverage is in place until application is approved and premium paid. All requested explanations and documents must be attached including: current declarations page, CV & currently valued loss runs.

NOTICE This is an application for a CLAIMS-MADE POLICY

1. (a) Applicant's Full Name: Degree/Title:
Other Name Used: Birth Date:
(b) Social Security #: (c) Federal DEA #: Male Female
(d) Home Address: Phone:
(e) Principal Office: Phone:
(f) Other Office Address(es): Fax:
(if any) Number Street City County State Zip Phone:
Email:

2. Specify States where you are licensed:
(License #) (State of Licensure) (Field) (License #) (State of Licensure) (Field) (License #) (State of Licensure) (Field)

3. (a) Medical Specialty: (b) Sub-Specialty: % of Practice:

If your specialty is Pain Management, Neurosurgery or Bariatric Surgery you will need to complete an additional procedure questionnaire.

4. (a) What is your average weekly patient load? (b) How many surgical procedures do you perform each week?

5. If my application is approved, make coverage effective on, if possible, otherwise on any other date set by the Company.

6. (a) Type of Practice (check all boxes that apply):
1. Individual (solo) Unincorporated 4. Member of Multi-person Corporation or Association 7. Other (Describe)
2. Individual (solo) Corporation 5. Employee of:
3. Partnership 6. Independent Contractor of:

(b) List Federal Taxpayer Identification Number(s) and name(s) of corporate entity(ies):
Entity Name Federal Taxpayer Identification Number
Entity Name Federal Taxpayer Identification Number

(c) Please list name(s) of ALL other partners, stockholders, associates, independent contractors and employed physicians. (Indicate status of each and provide proof of coverage for each).
1. Name Current Limits 3. Name Current Limits
2. Name Current Limits 4. Name Current Limits

7. (a) Are you American Board Certified in your Specialty? YES NO Date(s) Certified:
(b) Are you American Board Certified in your Sub-Specialty? YES NO Date(s) Certified:
(c) Name(s) of Specialty Board(s):

(d) If you are a foreign medical graduate, are you certified by the Educational Commission for Foreign Medical Graduates? YES NO
(e) Have you ever failed any Board Certification testing? YES NO
If YES, please explain:

## ATTESTATION QUESTIONS

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 8. <b>If the answer to any of the following is YES, please give full details (including dates) on a separate sheet of paper:</b>   |                          |                          |
| (a) Have you <u>ever</u> had professional liability insurance declined, canceled, issued on special terms or non-renewed?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Have you <u>ever</u> been investigated or are you currently being investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? (If YES, provide copies of all Accusations, Decisions, Consent Orders, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Has or is your license to practice medicine or your permit to prescribe or dispense drugs <u>ever</u> been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Have you <u>ever</u> had privileges at any hospital or other institution denied, reduced, revoked, restricted, or suspended?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Are you currently or have you <u>ever</u> been evaluated, treated or hospitalized for alcohol or drug abuse or a mental or emotional disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Have you <u>ever</u> been convicted of, or are you under indictment for, a felony?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Has your membership in any professional society or association <u>ever</u> been refused, censured, suspended or revoked?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Do you currently have or have you <u>ever</u> had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Are you currently or have you <u>ever</u> used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Has any physician, patient or insurance plan <u>ever</u> filed a complaint against you with any Medical Association/ Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Have you <u>ever</u> been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Have you <u>ever</u> been involved in a malpractice claim, suit or medical incident, either directly or indirectly, or are you presently involved in malpractice litigation? (If YES, please complete a Claims Information Form for each.)   | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Are you aware of any facts, circumstances, medical incidents, records requests or letters of intent that may give rise to a claim or suit? (If YES, please complete a Claims Information Form for each, attached to this Application).   | <input type="checkbox"/> | <input type="checkbox"/> |

## TRAINING & INSURANCE HISTORY

- |  |          |       |         |                      |                      |
|--|----------|-------|---------|----------------------|----------------------|
| 9. (a) Medical Degree from (school): _____ | City     | State | Country | Dates: _____         |                      |
|  |          |       |         | mm/dd/yy to mm/dd/yy |                      |
| (b) Internship: _____                      | Hospital | City  | State   | Country              | Dates: _____         |
|  |          |       |         |                      | mm/dd/yy to mm/dd/yy |
| (c) Residency: _____                       | Hospital | City  | State   | Country              | Dates: _____         |
|  |          |       |         |                      | mm/dd/yy to mm/dd/yy |
| (d) Type of Residency: _____               |          |       |         |                      |                      |
| (e) Residency: _____                       | Hospital | City  | State   | Country              | Dates: _____         |
|  |          |       |         |                      | mm/dd/yy to mm/dd/yy |
| (f) Type of Residency: _____               |          |       |         |                      |                      |
| (g) Fellowship Training: _____             | Hospital | City  | State   | Country              | Dates: _____         |
|  |          |       |         |                      | mm/dd/yy to mm/dd/yy |
| (h) Type of Fellowship: _____              |          |       |         |                      |                      |

10. List any additional medical specialty training:

<u>Location</u>	<u>Type</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. List malpractice coverage for the past 10 years, beginning with your current or most recent carrier:

Name of Insurer	Dates Covered From – To (MM/DD/YY)	Limits of Liability	Retro-active Date	Coverage Type (Occurrence or Claims-Made)	Premium	Was Tail Coverage Purchased?	# of Pending Claims	# of Closed Claims	Total # of Claims
A									
B									
C									
D									

- PLEASE ATTACH A COPY OF YOUR MOST RECENT DECLARATION'S PAGE AND POLICY.
- PLEASE FILL OUT A CLAIM INFORMATION FORM FOR EACH SUIT, CLAIM, LETTER OF INTENT AND INCIDENT, OPEN OR CLOSED, AND SUBMIT ANY ADDITIONAL INFORMATION RELATIVE TO THESE CLAIMS.

- (a) Do you intend to purchase a reporting endorsement (a.k.a. Tail Coverage) from your current insurer? YES  NO
- (b) If answer to (a) is NO, do you wish to obtain Prior Acts Coverage from us? **NOTE: The offering of Prior Acts Coverage is subject to Underwriter approval.** YES  NO
- (c) If answer to (b) is YES, please attach a copy of your present insurance policy, with all endorsements, and complete the following:

Applicant is/is not (circle one) as of this date aware of any Claims, Suits, Letters of Intent, Records Requests or Incidents that have not been reported to his/her (circle one) present or prior insurer(s). Please Initial: \_\_\_\_\_

**NOTE: If you do not purchase Prior Acts Coverage from us you will not have any coverage through us for any claim or suit based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued. We strongly urge you to consult your broker to discuss continuity of coverage and the implications thereof.**

### PRACTICE QUESTIONS

12. (a) Do you perform surgery in your office? YES  NO  (c) Is general anesthesia administered:
- (b) Do you perform surgery in any other non-hospital facility? YES  NO  1. By you? YES  NO
2. By others? YES  NO

If answer to (b) is YES, list and describe facilities where surgery is performed: \_\_\_\_\_

(d) List the surgical procedures you perform in your office or other non-hospital facility:  
 \_\_\_\_\_  
 \_\_\_\_\_

13. (a) Do you treat or review the treatment of prison inmates? YES  NO  % of practice: \_\_\_\_\_
- If YES, please explain (include facility names): \_\_\_\_\_

(b) Is insurance coverage provided for this work by the above facility? YES  NO

14. (a) Do you practice as a professional sports team physician? YES  NO  % of practice: \_\_\_\_\_
- (b) Do you practice as an amateur sports team physician? YES  NO  % of practice: \_\_\_\_\_
- If YES, please explain (include duties, team names and type of sport): \_\_\_\_\_

15. Do you perform medical legal evaluations? YES  NO  % of practice: \_\_\_\_\_
- If YES, with whom? \_\_\_\_\_

16. Do you treat or consult on patients in any sovereign nation or territory, other than the U.S., such as Native American or Alaskan Native lands?
- YES  NO  If YES, where? \_\_\_\_\_ % of practice: \_\_\_\_\_

17. Do you advertise your medical practice? YES  NO  If YES, what states: \_\_\_\_\_  
 If YES, list medium(s) and frequency for each: \_\_\_\_\_  
 If YES, provide copies of advertisements that you are currently using or have placed in periodicals, yellow pages, on flyers, handouts, etc. Please provide a copy of the script if you are using voice or film media.

18. Do you have any Internet Web-Site addresses? YES  NO  If YES, specify addresses: \_\_\_\_\_  
 \_\_\_\_\_

19. Do you perform consultations outside the state of your primary office address, including but not limited to, the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (tele-medicine or internet medicine) or do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address?  
 YES  NO  If YES, what percentage of your total practice: \_\_\_\_\_  
 If YES, identify all states in which such patients reside: \_\_\_\_\_

20. Do you treat patients who reside outside the state of your primary office address? YES  NO   
 If YES, what percentage of your practice: \_\_\_\_\_

21. List all locations where you have practiced in the last 10 years:

	<u>Group Name</u>	<u>Street</u>	<u>City</u>	<u>County</u>	<u>State</u>	<u>During Years</u>
(a)	_____	_____	_____	_____	_____	_____
(b)	_____	_____	_____	_____	_____	_____
(c)	_____	_____	_____	_____	_____	_____
(d)	_____	_____	_____	_____	_____	_____

22. Do you (YES  NO ) or your professional entity (YES  NO ) employ or contract for the services of any health care personnel? If YES, provide number of each and indicate if coverage (shared limits) is desired for each. **NOTE: If employed by an entity, coverage may not be available.**

	<u># Employed</u>	<u>Is Coverage Desired?</u>	<u># of Independent Contractors</u>	<u>Are they Insured?</u>
(a) Nurses (RN, LPN, LVN)	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(b) Medical Assistants	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(c) Technicians	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(d) Psychologists	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(e) Physical Therapists	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(f) Physician's Assistants**	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(g) Nurse Practitioners**	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(h) CRNA's**	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(i) Nurse Midwives**	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(j) Other: _____	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(k) Other: _____	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>

**\*\*If YES, please submit a written explanation of practice and procedures performed, along with certificate of course completion and license number. Provide proof of insurance if insured elsewhere. If coverage is desired, please complete a Professional Underwriters Liability Insurance Company Allied Personnel Application for each.**

23. Are you associated in any capacity with, or do you own, any of the following:

- (a) Any health care facility having bed and board accommodations? YES  NO
- (b) Any surgicenter, clinic, urgent care center, foundation, blood bank, laboratory, abortion clinic or birthing center? YES  NO   
 If answer to (a) or (b) is YES, are you:
1.  Owner (whole or part)    3.  Executive Officer    5.  Director of Ancillary Services Dept.    7.  Administrator  
 2.  Committee Member    4.  Medical Director    6.  Other (explain) \_\_\_\_\_
- (c) Any other medically related business enterprise? YES  NO   
 If answer to (c) is YES, please explain: \_\_\_\_\_

